

Implementing Models of Geriatric Care—Behind the Scenes

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Innovative geriatric clinical programs have proliferated in the 21st century, and many have been highlighted in the *Journal of the American Geriatrics Society* (JAGS). The Affordable Care Act has supported the accelerated innovation of publicized and unpublicized program development, adaptation, and implementation. Many JAGS articles report work conducted in programs with significant improvements in quality; high satisfaction for patients and providers; and for some, reductions in costs. Despite considerable detail, enabling implementers to attempt to adopt reported programs or adapt them to local environments, much less is typically conveyed about the subtleties of the implementation process that led to a successful outcome. Moreover, where we have been given a window into successful initiatives, far less is known about those that failed and even less about why some succeeded but others failed. With a focus on our shared needs as a geriatrics community, to foster the exchange of more-comprehensive models of successful and failed implementation, we propose publications that address implementation itself—a second layer of reporting about the “hidden” elements that may have been decisive factors in taking an efficacious test, treatment, or model and putting it into real-world practice. We propose a new platform for sharing a broader range of healthcare quality improvement initiatives—successes and failures. We include several salient characteristics that could be measured and described in support of dynamic, sustainable, evidence-based implementation of geriatrics programs. *J Am Geriatr Soc* 66:364–366, 2018.

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Health care in the United States has seen many changes in the 21st century, accelerated by the Affordable Care Act and a genuine interest in improving the quality of healthcare for all Americans. Many of these changes, some initiated before 2000, have occurred in settings focused on older-age care and have included innovative programs with well-known names such as Program of All-inclusive Care for the Elderly,¹ Geriatric Resources for Assessment and Care of Elders,² Improving Mood—Promoting Access to Collaborative Treatment,³ Care Transitions,^{4,5} and Interventions to Reduce Acute Care Transfers.^{6,7} Although adaptations of these and other programs have proliferated, most instances of implementation of these programs are unlikely to have received notice beyond their local sites and surrounding communities. The *Journal of the American Geriatrics Society* (JAGS) has born witness to a cross-section of this movement with several related publications, including eight Models of Care articles in 2016 alone.

These publications represent the successful efforts of healthcare practitioners, administrators, and patients who participated in the implementation and evaluation of innovative ideas. We know from our own experiences and those of our colleagues that JAGS and other journals have not published numerous reports of additional initiatives, because the quality of evaluation or its documentation was insufficient to merit publication; the implementers, although successful, chose not to submit their work for publication; or the implementation did not reach a level of achievement deemed worthy of documentation. Other initiatives may have failed to achieve goals that their originators established. Whether successful or not, only a fraction of these efforts of our healthcare colleagues who toil to innovate and improve care are likely to be widely known.

As clinical geriatrics programs increasingly move evidence into everyday practice, geriatricians and their healthcare teams and partners face many of the implementation-related challenges of other disciplines. Geriatrics providers

are challenged in busy clinical environments, striving to integrate new research findings into the care that they provide in clinics, hospitals, extended-care facilities, communities, and patients' homes. At the institutional level, many geriatricians have assumed leadership roles as a reflection of increasing awareness of the need to address systematically the healthcare problems that cannot be solved without large-scale structural solutions.^{8,9}

Whereas local context will dictate the need for a nuanced approach to implementation, many of the principles necessary for a successful strategy are broadly applicable, yet too little has been done to articulate and disseminate these principles beyond the more academic contributions of implementation science.^{10,11} Moreover, without more public sharing of successes, failures, the myriad of challenges, and the strategies deployed to meet those challenges, random activities, duplicative approaches less likely to be successful, and related inefficiencies will limit the success of well-intentioned implementers.

The field of implementation science has provided considerable guidance for considering, planning, executing, and sustaining an intervention. The well-known Consolidated Framework for Implementation Research^{12–14} comprises five domains: intervention, inner setting, outer setting, individuals involved, and implementation process (Table 1). This framework supports an important approach to implementation for design and evaluation, but learning more about a framework like this, and applying it, can be challenging; a full delineation of this evaluative framework is beyond the scope and intent of many descriptive publications about models of care, and many implementers lack the resources needed for a detailed evaluation that would address the framework's domains with any substantive depth.

To help implementers make progress in understanding and adapting useful models, single-site clinical programs are often described in JAGS in the Models of Care section. These are often highly successful, as significant improvements in quality; high satisfaction for patients and providers; and for some, reductions in costs indicate. Protocols may often be specific enough that motivated clinicians or administrators can replicate, often with local adaptations, these programs at their home institutions, with varying degrees of success. What is often replicated is an interdisciplinary model representing the skillsets of nurses, social workers, pharmacists, rehabilitative therapists, physicians, and other health professionals, such as psychologists, coaches, navigators, educators, "case managers," and health technicians. Community health workers are an increasingly important and recognized resource as we gain precision and clarity about essential clinical processes and the roles best suited to performing those processes.^{7,15–17} Overall, these interdisciplinary approaches reflect the complexities of need of our oldest, frailest patients. Robust protocols and supporting infrastructure, enhanced by health information technology, informatics, engineering, and human factors, reduce or accommodate certain complexities, and the ensuing organizational programmatic structure can increase the likelihood of success. Although these ingredients are essential for successful programs, they do not necessarily address the essential process of implementation, the human skills needed for achieving

successful and sustainable programs, and the challenges that are ever-present in our complex health systems. In other words, what really happened and what conclusions can be drawn from these experiences may be left unsaid.

With a focus on our shared needs as a geriatrics community, to exchange models of successful and failed implementation, we propose publications that address the implementation itself—a second layer of reporting about those "hidden" elements that may have been decisive factors in taking an efficacious test, treatment, or model and putting it into real-world practice. How did the process begin and with what construct or framework? How did it proceed and advance? What data were important for implementing, disseminating, and sustaining the program? In pursuing an agenda for healthcare innovation that relies on geriatric clinical knowledge, how were interpersonal sensitivities, and an acute awareness of formal and informal institutional structures that drive and impede otherwise sensible solutions to healthcare delivery problems,

Table 1. Consolidated Framework for Implementation Research¹²

Constructs	Definition
Intervention characteristics	Core (immutable) components; adapted components
Outer setting	Economic, political, social context surrounding an organization
Inner setting	Structure, networks—communications, culture, mood, readiness
Participant characteristics	Targeted users, others who are affected
Implementation process	Planned formal, informal activities, intended and unintended actions

Table 2. Proposed Additional Reported Characteristics of Models of Care Implementation

Constructs	Definition
Initiating conditions	Context, circumstances that made the opportunity possible
Skills, experiences of implementers	Description of all contributing individuals and their professional (formal) and personal (informal) skills and implementation experience
Interpersonal challenges	Challenges internal to team functioning and external to implementation team and how those challenges were met
Unique facilitators, barriers	Unique circumstances—structures or events—that served as a facilitator or barrier and how that was leveraged or addressed
Surprising conditions, events	What occurred or was discovered that was not anticipated; what role or influence, if any, that condition or event played in the implementation
Threats to, and requirements for, sustainability	What conditions or events raise concerns about a program's survival; how these are, or are not, being addressed What other resources or activities are needed for expanding

leveraged effectively? Where did the process fail? What unique opportunities shaped or forced an evolution that may not be present in other institutions? More than the model itself, the model's supports, requirements, surroundings, relationships, challenges, and opportunities would be the focus of these implementation publications (Table 2). This meta-process may be as important as documentation of the implementation process. We challenge local, regional, national, and international leaders who have implemented or disseminated innovative models of care to share, describe, and discuss their implementation processes, measurements of those processes, and dissemination of findings that speak to the challenges that identify not only the successes but also the failures, to prepare future implementers, and to expand this burgeoning field of creative, adaptive, dynamic, sustainable, evidence-based geriatrics implementation.

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